Naturopathic Intake Form

Date: .....

Name: _____ Age: _____

Parent Name if Minor: _____ Birthdate: _____/_____/_____ Gender: Female

Address: _____

City & County: _____ State: _____ Zip code: _____

Cell Phone: _____ Email: _____

Height_____Weight: _____ Occupation: _____

Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Emergency Contact: _____Relationship to Patient: _____

Contact's Phone: _____ Contact's email: _____

Who can we thank for referring you to Longevity Health Center: _____

Would you like to receive our informational newsletter, including coupons? Yes

Please List Any Known Allergies:

Drugs: _____ Environmental: _____

Foods:_____

PRIMARY HEALTH CONCERNS (Please list your primary health concerns in order of importance)

CONCERN Ex. Headache	ONSET June 1978	FREQUENCY 4 times/week	SEVERITY Mild/Moderate/Severe
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....

ADDITIONAL HEALTH HISTORY AND TIMELINE – Significant changes and onset of illness

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PERSONAL MEDICAL HISTORY & LIFESTYLE

Do you have a pacemaker? No **Have you had any organ transplants?** No **Organ?** .....

Please list any operations, surgical procedures, blood transfusions, major injuries (with dates):

.....

.....

Immunizations/Vaccinations

Blood Type

Childhood	Flu	Shingles	Pneumonia	Covid	Other: .....
Delayed	No	No	No	No	No

Date of last physical exam: ..... Date of last blood tests: .....

Hours of sleep per night: ..... Quality of sleep: Good

List physical activities and frequency: .....

Number of 8 ounces glasses of water per day: .....

Tobacco Use (Cigarettes, Pipe, Cigar, Chew, Vaping)-(Past/Present): No **How Much, How Long?)** Quit? Y No

Do you regularly use:

Alcohol	Coffee	Tea	Carbonated Beverages	Energy Drinks
No	No	No	No	No
How much?	How much?	How much?	How much?	How much? .....

How many amalgam fillings (silver)do you have? ..... Have you had any fillings removed? No

How many root canals do you have? ..... Crowns? ..... Implants: .....

How often do you have a bowel movement: ..... times per day. .....

What brand of toothpaste do you use? ..... Deodorant brand? .....

Are there any high-tension power lines, transformers, 5G towers near your home or work? .....

Have you ever had a known mold exposure? .....

If so, how long were you living/working in the environment? .....

If so, are you still living/ working in that environment? .....

Have you ever suffered from an extreme trauma, either emotional or physical? .....

Do you have a good support system? .....

Birth Story: Vaginal _____ C-Section _____ Were you breastfed? _____

Do you have any pets? If yes, what type?

CURRENT MEDICAL HEALTH CARE TEAM

Primary Care Physician: .....

Specialist: ..... Specialty: ..... Dx: .....

Specialist: ..... Specialty: ..... Dx: .....

OTHER HEALTHCARE TEAM MEMBERS (massage therapist, nutritionist, acupuncturist, chiropractor, etc.)

Practioner: ..... Specialty: ..... Frequency: .....

Practioner: ..... Specialty: ..... Frequency: .....

MEDICATIONS

What medications are you taking now? (include prescription & over-the-counter drugs)

MEDICATION	REASON	WHEN STARTED	DOSAGE PER DAY
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....
5.	.....	.....	.....
6.	.....	.....	.....

Describe any history of drug reaction/allergy: .....

SUPPLEMENTS

What vitamin / herbal / nutritional supplements are you taking?

SUPPLEMENT	REASON	WHEN STARTED	DOSAGE PER DAY
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....
5.	.....	.....	.....
6.	.....	.....	.....

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WOMEN ONLY

Date of last menstruation: ..... Age at onset of menstruation: .....

Period every how many days? .....

Heavy periods, irregularity, spotting, pain or discharge? No .....

Are you now on or have you ever taken birth control? ..... How long? .....

Number of pregnancies: ..... Number of live births: .....

Are you pregnant or breastfeeding? .....

Have you had a D&C, Hysterectomy or Cesarean? .....

Any urinary tract, bladder, or kidney infections within the last year? .....

Any blood in your urine? ..... Any problems with control of urination? .....

Any hot flashes or sweating at night? .....

Do you have menstrual tension, pain, bloating irritability, or other symptoms at or around the time of menstruation? No

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Experienced any recent breast tenderness, lumps, or nipple discharge? No .....

Date of last Pap? ..... Normal

Have you had cosmetic surgery? .....

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MEN ONLY

Do you usually get up to urinate during the night? No If yes, # of times: .....

Do you feel pain or burning with urination? No .....

Any blood in your urine? No .....

Do you feel burning or discharge from penis? No .....

Has the force/flow of your urination decreased? No .....

Have you had any kidney, bladder or prostate infections in the last 12 months? No .....

Do you have any problems emptying your bladder completely? No .....

Any difficulty with erection or ejaculation? No .....

Any testicle pain or swelling? No .....

Date of last PSA: ..... Normal? ..... Elevated? .....

Have you had cosmetic surgery? .....

PLEASE GIVE A GENERAL DIET SUMMARY FOR THE LAST THREE DAYS

	BREAKFAST	LUNCH	DINNER	SNACKS
DAY 1				
DAY 2				
DAY 3				

Nutritional Goals: _____

Weaknesses / Cravings: _____

Foods you currently avoid: _____

SYMPTOM PROFILE

Patient Name: ..... Date: .....

Please rate the severity of your symptoms

Rate from 1(Least) 10 (Worst)

	LEAST WORST
Brain Fog	1
Neck/Upper Back Pain	1
Joint/Muscle Pain Location	1
Headaches/Migraines	1
Blurry Vision/ Floaters	1
Digestive Dysfunction Gas/Bloating Indigestion/Reflux Diarrhea/Constipation	1
Sleep Disturbance Insomnia / Trouble Falling Asleep / Trouble Staying Asleep	1
Fatigue/Exhaustion	1
Anxiety	1
Depression	1
Cardiovascular Issues / Circulation Cholesterol / BP / AFib / Palpitations/ Tachycardia / POTS	1
Sinus / Chest / Lung / Ear / Throat – Congestion	1
Skin – Acne / Eczema / Psoriasis / Rash	1
Urinary Tract / Kidney Dysfunction	1

OTHER:

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Authorization to Release Health Information

I authorize **Longevity Health Center** to disclose my protected past, present and future health information to the following persons or entities:

_____ _____

This health information may be used by the person I authorize for health treatment or billing/payment purposes. This authorization will remain in effect until such time as I choose to revoke the authority in writing.

Signature **Date**

STATEMENT OF UNDERSTANDING

I acknowledge that the modalities utilized by **Alice Honican, DTCM, ND, L.Ac., Anna Powers, ND, Cristina McMullen, ND, and Maria Jones, ND,** at Longevity Health Center are not approved for medical evaluation or diagnosis. The bio-energetic assessments performed may indicate "disturbance signals" related to microbial or environmental pollutants, but these are not to be interpreted as a medical diagnosis. The information gathered is intended solely to guide the development of a recommended protocol for holistic wellness.

I also understand that none of the practitioners or staff members at Longevity Health Center are medical doctors. I voluntarily choose to undergo an evaluation and treatment based on oriental medical principles, including traditional and modern acupuncture techniques.

CANCELLATION POLICY – $50 Missed Appointment Fee

We strive to provide timely and quality care to all our patients. To ensure the availability of appointments, please be aware of the following policy:

- **Late Cancellations:** Appointments must be canceled at least 24 hours in advance. If you cancel with less than 24 hours' notice, it will be considered a late cancellation.
- **No-Shows:** A no-show occurs when a patient misses an appointment without prior notice.

In either case, a **$50 missed appointment fee** will be charged. When you book an appointment, you reserve a time slot that could have been offered to another patient. Timely cancellations allow us to accommodate other patients in need of care.

If you need to cancel your appointment, please call us at 770-642-4646 between 9:00 AM and 5:00 PM. If you call outside of business hours, please leave a detailed voicemail. We will return your call as soon as possible.

I have read and understand the above CANCELATION POLICY.
I have read and understand this STATEMENT OF UNDERSTANDING.

⏩ ⏩ _____

Signature of Patient (or Parent of Minor) **Date**